Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1260

DATE: July 3, 2013

TO: Iowa Medicaid Hospitals, Physicians, Advanced Registered Nurse Practitioners, and Certified Nurse Midwives

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Elective C-Section Coverage and Payment – FOLLOW UP

EFFECTIVE: July 1, 2013

As noted in Informational Letter (IL) 1249, the Iowa Legislature mandated that the Iowa Medicaid program no longer provide coverage of, or payment for, elective, non-medically necessary Cesarean section (C-section) deliveries. This change is effective July 1, 2013, and aligns with initiatives being undertaken by the Iowa HealthCare Collaborative, as well as by various individual hospitals and hospital systems.

Responses to questions from providers about how this mandate will be implemented by the IME are noted below.

- What will IME use to determine the medical necessity?

  Response: The IME has developed a list of ICD-9 diagnosis codes that reflect the medical necessity and appropriateness for a C-section (see table below). The diagnosis code list is split into three parts. The first is diagnosis codes that will always be payable (i.e., Group 1), the second is diagnosis codes that will require documentation to determine medical necessity and payment (i.e., Group 2), and the third list is diagnosis codes that will not be payable (i.e., Group 3). A table with these different diagnosis groups is on the following page.

  - A claim with a diagnosis code(s) from Group 1 in any position on the claim will allow the C-section claim to be processed without upfront review of documentation.

  - A claim with a diagnosis code(s) from Group 2 must include documentation with the claim in order to be considered for payment. Claims with a Group 2 diagnosis without documentation will deny.

  - A claim with a diagnosis code(s) from Group 3 will deny.

IMPORTANT NOTE: Relative to the diagnosis code ranges in the table below, ONLY VALID DIAGNOSIS CODES WITHIN EACH LISTED RANGE MAY BE USED. This additional clarification is being provided because many of the code ranges listed below show a "5th" digit of "9", because in some cases the actual highest available 5th digit is "9". However in some cases, the actual highest 5th digit in a given code range might be a number lower than 9. EXAMPLE from Group 1: "660.00 – 660-99". For this code range, the actual highest 5th digit is 660.93. The use of a "9" as a 5th digit in the table below is intended to provide a consistent general listing of these code ranges. As such, the ranges list the possible beginning and ending points.

Group 1 Diagnosis Code Range		Group 2 Diagnosis Code Range		Group 3 Diagnosis Code Range	
641.00	641.29	642.00	642.99	669.70	669.79
645.20	645.29	645.10	645.19		
647.60	647.69	646.00	646.29		
651.00	651.99	646.60	646.99		
652.00	652.09	647.70	647.99		
652.20	652.99	648.00	648.99		
653.00	653.99	649.00	649.49		
654.00	654.49	649.60	649.89		
654.60	654.99	652.10	652.19		
655.00	655.09	654.50	654.59		
656.30	656.39	655.10	655.99		
659.00	659.19	656.00	656.29		
659.70	659.79	656.40	656.99		
660.00	660.99	658.00	658.99		
661.00	661.29	659.20	659.69		
661.40	661.89	659.80	659.99		
662.00	662.99	661.30	661.39		
663.00	663.99	661.90	661.99		
665.00	665.19	665.20	665.99		
678.10	678.19	668.00	668.99		
V27.2	V27.7	669.00	669.29		
		669.80	669.99		
		673.00	673.99		
		679.00	679.99		
		642.00	642.99		

- Will documentation need to be submitted or has the MMIS system been updated with specific diagnosis codes that will require review?

  Response: For C-section claims including one of the diagnosis codes listed in Group 1 **no documentation will be needed** and no front-end review will be done. The IME has hard-coded these diagnosis into the MMIS and added corresponding edits, so that claims which include one or more of the diagnosis codes from Group 1 will be processed

without an upfront review of documentation. Claims with a diagnosis code(s) from Group 2 **will require documentation and will deny without such documentation**. Claims with a diagnosis code(s) from Group 3 will deny. Denied claims that have a diagnosis from Group 2 and which were denied for no documentation may be resubmitted by the provider receiving the denial with the required documentation and without the need for a provider inquiry.

As with any denied claim, providers will be able to submit a provider inquiry, along with any relevant and necessary documentation. Any consideration of any such denied claim will be on a case by case basis.

- Will a repeat Cesarean section or C-section following prior vaginal delivery also need to show medical necessity?

  Response: Claims for repeat C-sections or C-sections following a prior vaginal delivery will be handled in the same manner as any other C-section claims, as described above.

- Will all providers involved in the C-section need to use the same diagnosis codes on their respective claims?

  Response: Yes. In order to assure proper payment, the claims from the hospital, anesthesiologist, assistant surgeon (if applicable), or any other involved providers who would be submitting their own separate claims should also follow the guidance in this IL. Relative to diagnosis codes associated with the C-section, and as appropriate, these other providers should coordinate with the physician who performed the C-Section, as needed. This will assure all payable claims from all involved providers are paid appropriately.

- Will all providers involved in the C-section need to submit documentation for C-section claims requiring documentation?

  Response: Yes. In order to assure proper payment, the claims from the hospital, anesthesiologist, assistant surgeon (if applicable), or any other involved providers who would be submitting their own separate claims would need to include similar documentation related to the C-section which will support its medical necessity. Relative to documentation from the other providers, and as appropriate, these other providers should coordinate with the physician who performed the C-Section, as needed. This will assure all payable claims are paid appropriately.

- Can the provider resubmit denied claims with supporting documentation through normal claims channels?

  Response: Yes. However, this would only involve claims with a diagnosis code(s) from Group 2. The provider should send documentation with any claim that has a diagnosis from Group 2.

- What if the diagnosis code billed is not in Group 1 or Group 2 from the table above, but is the most appropriate diagnosis code given the patient's situation?

  Response: The provider will need to submit supporting documentation as a provider inquiry for Medical Services staff to review.

- Can the provider submit an appeal on a denied C-section claim?

  Response: Yes, as would be the case with any denied claim. However, if a claim with a Group 2 diagnosis has been denied more than once, a better option to avoid the normal delays associated with the appeal process would be for providers receiving a denial on a C-section claim to submit a provider inquiry with documentation. That inquiry and documentation would be reviewed by IME Medical Services staff to determine medical necessity and further process the claim as appropriate.

Please be advised that, as with any claim submitted to and paid by the IME, paid C-section claims will be subject to post-payment review by the IME Program Integrity Unit.

If you have any questions, please contact the IME Provider Services Unit at 1-800-338-7909, or locally at 515-256-4609, or by email at imeproviderservices@dhs.state.ia.us.